MIAMI-DADE COUNTY

ACCIDENTAL DEATH INSURANCE

☐ Change of Beneficiary
☐ Change of Name
Former Name _____

☐ Other _____

Name of Employer	Department	Division
Name of Employee (Last, First, Middle)		**Date of Birth**
Social Security No.	**Occupation**	
Name of Beneficiary (Last, First, Middle)		**Relationship to Employee**

_____ _____

Date Signature of Employee

INSTRUCTIONS – DISTRIBUTION: White/Department – Blue/Employee – Yellow/Central Personnel files
Send white copy to Insurance Management Division in the event of on-the-job death of employee.

160_05-36 3/06